ISSN 0838-4762

Physicians' newsletter

Published by the Medical Services Plan for Medical Practitioners

inside

Issue 2 Volume 26 Fall/Winter 2002

The New CDM Web site 1
A New Angel Flies the Local Skies 2
Stat Holidays 2
Flu Shots 3
2003 Close-off Dates 3
Criteria for Approval of New Bone Densitometry Facilities 3
No CPR and DNR Forms 4
Northern and Rural Locum Program 4
Billing for Delegated Procedures –Preamble B 5 5
Home Visits 5
Audit Reports 6
Explanatory Code "BH" 8
Important Reminder 8
Billing Errors identified by Audit 8
MSP CareCard Replacement Fee 9
New Legislation 9
Rural Retention Program 9
MSP Premium Billing 9
Pharmacare Special Authority Process 10
Pharmacare Contact Info 12
Drugs under review 12
New Explanatory Codes 13
Lab Requisition Forms 13
Changes to Payment Schedule 13
Surgical Assists for Concurrent Surgery to Different Patients 14
MSP Bulletin 15
Audiograms 16
Update to Teleplan 16
NITAOP 16
List of Inserts ..... ***Last Page***

The New Chronic Disease Management Web Site

http://www.healthservices.gov.bc.ca/cdm

The Ministries of Health Services and Health Planning are pleased to announce a new Chronic Disease Management (CDM) Web site that will be of particular interest to B.C. physicians and their patients.

The Web site brings together, in one place, information on various CDM activities and developments in British Columbia, including recent prevalence and utilization information; approaches to care and patient resources.

The site consists of three sections.

For patients, the site provides general references and information about chronic conditions, with an extensive resource area on diabetes. It is expected that the patients' section will expand to include other chronic diseases as work develops in the province.

For physicians, the site offers a number of articles and reports and includes information on improving clinical management of chronic diseases, patient registries, performance measures and clinical practice guidelines developed for chronic diseases.

Of interest to physicians, health professionals and the public, is the section called CDM in B.C. This section includes the latest developments in chronic disease management in B.C., research and reports, and background information on the Chronic Care Model adapted for use in the province.

The CDM Web site is expected to expand rapidly over the next year, and health authorities, physicians and patients are welcome to provide input in the further development of this exciting new resource.

A New Angel Flies the Local Skies

There's a new angel spreading its wings over Victoria – but you won't see any feathers flying.

Instead, pilots who volunteer their time are making life a whole lot easier for children and adults with life-threatening diseases through an organization called Angel Flight of Vancouver Island.

It's the first organization of its kind in Canada to provide free air transportation for patients who must travel to Vancouver for treatment.

"It's critical for some cancer patients to travel" says Angel Flight founder and president, Chuck Lovallo. "But the discomfort of the travel just adds to their suffering."

A one-way ferry trip can last up to four hours. Through Angel Flight, travel time can be reduced to as little as 90 minutes by air and with limited ground transport.

Although it is the Society's aim to offer this service to everyone who has to travel, the initial priority is for high-risk cancer patients on the Victoria-Vancouver route. Expansion to other island points is underway.

Here's how it works: a cancer patient and their guardian are flown to Vancouver South Terminal where a Canadian Cancer Society volunteer driver meets them. When they are finished, it all happens in reverse. This service is provided free through the generosity of corporate sponsorships and private donations.

The small single engine aircraft used for Angel Flights fly at altitudes of up to 6,000 feet and are not pressurized so patients must be fit enough to undertake the flight without a detrimental effect on their health. Angel Flight requires a doctor's clearance before a patient can be transported. Due to the type of aircraft used, all patients and their escorts must be ambulatory.

Angel Flight of Vancouver Island is a non-profit registered charity that launched full flight operations in April 2002. Familiarization flights were conducted prior to the launch to ensure every aspect of the service operated safely and smoothly. To date, 25 flights and14 patients along with their escorts have been accommodated. The society's service will not compete or displace any commercial or government charter or air ambulance service.

Angel Flight has been approved by the Victoria Airport Authority, Vancouver Airport Authority, Transport Canada, NAV Canada, the Provincial Ministry of Health Services, MSP, Canadian Cancer Society, sponsors, suppliers and volunteers.

It's Board of Directors is prepared to help others who may wish to join as affiliates of Angel Flight. "We've already had enquiries from other communities," said Chuck Lovallo. He says they will be ready to provide interested parties with advice and a comprehensive administration and flight operations manual to get them started.

For more information visit their Web site:
http://www.angelflight.ca/

MSP's Travel Assistance Program (TAP) welcomes its newest travel partner, Angel Flight. If you are referring your patient between Vancouver Island and Vancouver, a *Request for Travel Assistance* application must be completed at time of referral. Your patient must contact TAP at 1-800-661-2668 or (in Victoria) at 952-2657 for a confirmation number prior to contacting Angel Flight.

DESIGNATED STATUTORY HOLIDAYS – YEAR 2003

January 1, 2003	New Year's Day	Wed
April 18, 2003	Good Friday	Fri
April 21, 2003	Easter Monday	Mon
May 19, 2003	Victoria Day	Mon
July 1, 2003	Canada Day	Tue
August 4, 2003	B.C. Day	Mon
September 1, 2003	Labour Day	Mon
October 13, 2003	Thanksgiving Day	Mon
November 11, 2003	Remembrance Day	Tue
December 25, 2003	Christmas Day	Thur
December 26, 2003	Boxing Day	Fri

Flu Shots

Influenza vaccine will be available November 2002. A physician's recommendation for influenza immunization is the most significant factor in their patient's decision to be immunized. Encourage the patients in your care to get immunized against influenza.

Flu Shots should be billed under fee item 00010 (intramuscular medications) for any person eligible to receive the free influenza vaccine. A visit fee should not be billed if the flu shot was the sole reason for the visit.

Influenza vaccine is provided free to people 65 and over, adults and children with chronic health conditions, independent health care practitioners (e.g. doctors, nurses and dentists), health care workers, staff in care facilities, caregivers and emergency responders (police, fire and ambulance workers).

Only those persons eligible for publicly funded vaccine should have their flu shots billed to MSP. Charging an eligible person, for either the vaccine (serum) or the injection is in contravention of the *Medicare Protection Act* Part 4 Section 17(1).

Please refer to the following Web site for more information about influenza http://www.healthservices.gov.bc.ca/bchealthcare/healthtopics.html#flushots

2003 Close-off Dates

January 5, 2003
January 21, 2003
February 4, 2003
February 18, 2003
March 4, 2003
March 19, 2003
April 3, 2003
April 16, 2003
May 5, 2003
May 20, 2003
June 3, 2003
June 18, 2003
July 3, 2003
July 21, 2003
August 5, 2003
August 19, 2003
September 3, 2003
September 18, 2003
October 2, 2003
October 21, 2003
November 3, 2003
November 18, 2003
December 3, 2003
December 16, 2003

Criteria for Approval of New Bone Mineral Densitometry Facilities

Pursuant to Section 51(2)(f) of the *Medicare Protection Act* the *Guidelines for Recommending Approval/Denial when Reviewing Applications for Diagnostic Facilities* are amended as follows.

Addition:

The Advisory Committee on Diagnostic Facilities (ACDF) will consider reasonable access for Bone Mineral Densitometry (BMD) testing to exist where and when beneficiaries may find appointments available for the service at an approved diagnostic facility within approximately one hour travel time and within approximately one month wait time.

Providers, regardless of practitioner specialty or facility class or category, are eligible for BMD approval as a diagnostic facility, subject to accreditation by the Diagnostic Accreditation Program of the College of Physicians and Surgeons of B.C.

The ACDF will not presume MSC approval for any Facility or any class or category. The ACDF should recommend approval of any BMD Facility only with due regard to the above guidelines concerning accessibility and proximity, and any other condition or requirement given by the MSC, consistent with statutory authority. As stated in its Guidelines, the ACDF should not recommend approval, without reasonable justification, where projected service volumes would exceed the current provincial average per capita frequency for the expected service population.

NO CPR AND DO NOT RESUSCITATE FORMS

The new *No CPR* form and its extension, the No CPR Bracelet option, replaces the old *Do Not Resuscitate* form.

Since the mid-nineties, British Columbians who have been diagnosed as having a terminal illness or are considered to be near the natural end of life have had the option of asking their physician to complete a Do Not Resuscitate (DNR) Order on a prescribed form.

The DNR form is now out of date and must be replaced by the new *No CPR* form. If you have old DNR forms left, please dispose of them and order the replacement, the *No CPR* form.

The "No CPR" bracelet option is an extension of the *No CPR* form. Both options reflect applicable consent provisions of the *Health Care (Consent) and Care Facility (Admission) Act*, which came into effect in February, 2000. Existing signed DNR forms continue to be valid, but updating must be done using the new *No CPR* form.

Physicians can order copies of the triplicate *No CPR* form (form HLTH302.1/NO CPR Revised 01/05/01) from the Government's Product Distribution Services, Customer Service at fax: 250-952-4442.

Since June 1, 2001, any person for whom a *No CPR* form has been completed has the option to register with Canadian MedicAlert® Foundation and obtain a No CPR MedicAlert bracelet. British Columbia is the first province in Canada to implement this program. The MedicAlert No CPR bracelet provides easily recognizable verification that a No CPR order is in place. Financial support may be available for individuals unable to pay for the bracelet cost themselves.

For a copy of the MedicAlert brochure describing the process for ordering the British Columbia No CPR bracelet, please call MedicAlert at: 1-800-668-1507 or visit their Web site: www.medicalert.ca

To ensure a No CPR bracelet is worn only by a person with a No CPR order, MedicAlert will mail the bracelet to the patient's physician who will place the bracelet on the patient's wrist and review its purpose with the patient, the patient's family and/or care providers. The No CPR bracelet will have the patient's name and unique MedicAlert membership number and the number of the patient's *No CPR* form on it.

When shown a copy of a completed DNR or *No CPR* form, or if the patient is wearing a MedicAlert® "No CPR" bracelet on his/her wrist, paramedics are relieved of their responsibility to resuscitate the patient.

NORTHERN AND RURAL LOCUM PROGRAM

The Northern and Rural Locum Program (NRLP) helps general and family practitioners working in small B.C. communities to secure subsidized vacation relief. It also provides physicians an opportunity to experience rural practice in some of the most beautiful communities in B.C.

Effective August 1, 2002, the daily rate for a locum contracted with the NRLP will increase from $600.00 per day to $750.00 and travel time from $500.00 to $600.00 per return trip.

Locums contracting with the NRLP will continue to be eligible for on-call funding while on assignment. The Health Authority (HA) will be responsible to ensure that the applicable on-call rate is paid to the locum. It is the responsibility of the locum to ensure that the HA is informed of the call days/hours worked. The NRLP will continue to reimburse the locum physician the daily rate of $750.00 per day for each day worked.

If you have questions or comments about the NRLP please contact: Sharron Wickens or Dianne Hiley, MSP at 250-952-3042 or Heather Campbell, BCMA at 604-638-2827.

Billing for Delegated Procedures – Preamble B.5

The following information from *MSC Payment Schedule Preamble B.5* is a reminder of the requirements for billing procedures that may be performed by nurses or other non-physician medical assistant personnel. This applies to all hospital (even though hospital employees are not in the direct employ of a physician) or office based out-patient procedures but does not apply to:

- "visit" type services such as examinations/ assessments (including visual fields, audiograms etc.), consultations, psychotherapy and counselling which cannot be delegated.

- approved out-patient procedures rendered in approved "diagnostic facilities" such as laboratory medicine, diagnostic radiology, nuclear medicine, pulmonary function, CT and electrodiagnosis (including ECG's, EEG's, EMG's and polysomnography) or the taking and collecting of specimens.

Procedures generally accepted as those that may be carried out by a nurse or other non-physician medical assistant in the employ of a physician may, be billed to the Medical Services Plan (MSP) by that physician when the performance of the procedure is under the direct supervision of the physician or a designated alternate physician with equivalent qualifications. Direct supervision requires that during the procedure, the physician be physically present in the office or clinic at which the service is rendered. While this does not preclude the physician from being otherwise occupied, he/she must be in personal attendance to ensure that procedures are being performed competently and he/she must at all times be available immediately to improve, modify or otherwise intervene in a procedure as required in the best interest of the patient.

Billing for these procedures also implies that the physician is taking full responsibility for their medical necessity and for their quality. Any exceptions to this rule are subject to the written approval of MSP.

Physicians' Resource Manual – Correction Fee Item 01210

An error was recently found on page 6-87, "Example 4" in the *Physicians' Resource Manual*, Section 6.2 (Billing Guide for Emergency Visits and Out-of-Office Hours Premiums).

In Example 4, fee item 01210 (or any other surcharge) would not be applicable, as the surgery does not commence within the designated times. As outlined in the *MSC Payment Schedule*, explanatory note "a", Out-of-Office Hours Premiums section – "The out-of-office hours premium listings apply only to those services initiated and rendered within the designated time limits".

Although, every effort is made to ensure that information provided in the *Physicians' Resource Manual* is accurate and up to date, billing information is provided as a guide only, and is not meant to replace a thorough understanding of the *MSC Payment Schedule*. This example has been corrected on the MSP web site. We apologize for any confusion this error may have caused.

Home Visits (Fee items 00103/00104)

The BCMA Tariff Committee recently provided the following clarification about claims for home visit fees (fee items 00103/00104) to patients in the same apartment building.

The home visit items were established to compensate the physician for travel time in addition to the "visit" service provided. These items are only billable for visits that are initiated by the patient and that occur on the same day that the patient requested the service. If, by coincidence, the physician is called by two patients who reside in the same apartment building, but in two different domicile units, fee item 00103 may be claimed for each patient. If two patients are seen within the same domicile unit, fee item 00103 may be charged for the first patient, and fee item 00104 may be charged for the second patient seen.

If the visits are scheduled and set up by the physician ahead of time, only the appropriate out-of-office visit fee should be billed (e.g. fee item 13200 or 13300).

General Practitioner

Unusual practitioner profile statistics, service verification audit irregularities and patient complaints led to the audit of a general practitioner. Auditors found evidence of billing irregularities involving fee items 00120 (prolonged visit for counseling), 00101 (complete examination) and numerous out-of-office services (*MSC Payment Schedule Preamble B-4 a and 4 c*).

Services rendered to members of the practitioner's family and other persons were also inappropriately billed. The *MSC Payment Schedule Preamble A-19* states that services are not a benefit of MSP if a medical practitioner renders them to members of the practitioner's family or members of the same household.

The practitioner has agreed to repay the Medical Services Commission a total of $48,556 for the inappropriate billings. The practitioner has also agreed to abide by a pattern of practice order requiring that future billings comply with the requirements of the *MSC Payment Schedule*.

General Practitioner

A general practitioner who was recently audited has reached an agreement with the MSC. Issues included keeping adequate and complete medical records in accordance with the requirements of the *MSC Payment Schedule* to support the billing of fee item 00101 (complete examination) and fee item 00120 (prolonged visit for counseling). Preamble B-4 a and 4 c state the necessary requirements for billing these fees.

The practitioner has agreed to repay the Commission a total of $12,500 and to comply with a pattern of practice order.

General Practitioner

In a recent audit, the MSC identified issues with a physician's use of fee item 00120 for prolonged counseling visits. The physician has agreed to make repayment of $6,500 and to abide by a pattern of practice order.

As part of the order, the physician agreed that he will only claim for a prolonged counseling visit when the criteria for fee item 00120, listed in the Commission's *Payment Schedule Preamble B-4 c*, are met.

General Practitioner

Following an audit, the MSC and a doctor reached a settlement in a dispute about billings. The doctor has agreed to make repayment of $20,000 relating to fee item 00100 (office visit) and fee item 00120 (counselling visit).

The doctor further agreed to maintain adequate clinical record to support fee item 00120, which references the difficult nature of the patient's condition and the time spent with the patient, as outlined in Preamble B-4 c.

General Practitioner

A recent audit determined that a physician lacked adequate documentation of the existence of a difficult medical condition in support of billing fee item 00120 (prolonged visit for counseling). Preamble B-4 c states the necessary requirements for billing this fee.

The physician has agreed to make restitution in the amount of $17,000, adopt a pattern of practice, and maintain complete and adequate clinical records in accordance with Preamble B-2.

General Practitioner

A general practitioner and the MSC have reached a settlement in a dispute involving the inappropriate billings of fee item 00112 (emergency visit), and fee item 00120 (prolonged visit for counseling) and fee item 00044 (minor tray fee). Reference to billing fee item 00112 is on page 7-9 of the *Payment Schedule*.

The terms of the agreement provide that the physician make restitution in the amount of $19,000, adopt an appropriate pattern of practice and agree to maintain complete and adequate clinical records in accordance with the *MSC Payment Schedule*.

General Practitioner

A practitioner has recently agreed to make restitution of $40,000 relating to the following problem billing areas that were discovered following an MSC audit:

- billing of routine office visits to both the Medical Services Plan and the Workers Compensation Board, when services should be billed to one insurance plan only

- more frequent billing for patients whose documented medical condition, according to the physician's records did not warrant it

Information regarding multiple insurers (WCB, ICBC) is included in the Medical Services Plan Resource Guide for Physicians section 6 page 29.

Orthopaedic Surgeon

An orthopedic surgeon and the MSC have reached a settlement after a recent audit uncovered inappropriate billings. The practitioner has agreed to a pattern of practice order and to make restitution of $20,000 relating to the following billing areas:

- Out-of-office surcharges (fee item 01202) were billed when continuing care surcharges (fee item 01207) were appropriate (Section 2 pages 1-2 of the *MSC Payment Schedule*)
- Total hip prosthesis (fee item 55663) was billed when hip hemi-arthroplasty (fee item 55662) was performed.
- Inappropriate fee items for services not included in the *MSC Payment Schedule*, which should have been billed under a miscellaneous fee code accompanied by a written explanation. (Preamble A-7)
- Inaccurate application of *MSC Payment Schedule* fee items and procedures for multiple surgeries. (Preamble B -9 e)

General Practitioner

A general practitioner was selected for audit due to actual expenditures for GP and diagnostic services being statistically higher than expected. A review of the clinical records was conducted to determine whether the actual costs were justifiable, based on the health status and medical needs of the patients.

The review found that many of the patients served by the practitioner were new Canadians that had a number of social, economic and cultural issues. These factors justified some of the observed differences in the patterns of practice. Despite these factors, the level of servicing was determined to be excessive after consideration of the health status of the patients. Through a process of negotiation, the practitioner agreed to restitution of $110,000 for services provided personally, inclusive of costs.

The review also found that the expenditures for diagnostic tests, allowing for a higher than expected incidence of certain conditions, could reasonably be expected to be above average. Nevertheless, the actual costs appeared to exceed an amount that was reasonable and justifiable. The Commission has the right to pursue recovery of diagnostic test costs from the ordering physician, even though he or she may not have derived a direct financial benefit.

The Commission agreed to defer any action to recover the excess cost from the practitioner in this case, contingent upon future test ordering patterns. The practitioner has also agreed to abide by an appropriate pattern of practice order. The Commission will continue to monitor this physician to insure compliance with the order.

Urologist

The MSC and a physician reached an agreement in a dispute about billings of fee item 001202 (call-out charge for Saturday, Sunday or statutory holiday) in non-emergency, non-elective situations.

Fee item 001202 can only be billed where the physician is specially called to render emergency or non-elective services. In addition, the physician must travel from one location to another to attend the patient, the service must be rendered within specific time limitations and the physician's office must be officially closed during the designated time.

The physician has signed a pattern of practice order indicating that all future billings of this nature will be undertaken in accordance with the *Payment Schedule*.

General Practitioner - Dr. Patrick Nesbitt #03996

Following an audit, the Medical Services Commission and Dr. Patrick Nesbitt, general practitioner reached a settlement in a dispute about billings. Issues included:

1) Use of fee item 00120 for prolonged counseling visits; and
2) Certain billings for persons who had accompanied patients to his office and had communicated with him, but did not themselves receive an MSP insured service.

Dr. Nesbitt has agreed to make restitution of $90,000 and to abide by a pattern of practice billing directive. As part of the directive, Dr. Nesbitt agrees that he will not submit a claim to MSP for communications with a person accompanying a patient, when that communication would be considered a normal and routine part of the service for the patient.

continued on page 8

continued from page 7

Dr. Nesbitt further agrees that he will only submit a claim for the "accompanying person" if:

a) the criteria in the *MSC Payment Schedule* for submitting a claim on behalf of the accompanying person for fee item 00120 are met or;
b) the accompanying person has a medical condition themselves for which they require and receive medical treatment

Dr. Nesbitt has also agreed to bill fee item 00120 (prolonged visit for counseling) only when the criteria in the *MSC Payment Schedule* are met. In particular, he must maintain adequate clinical records supporting the billing of 00120 (prolonged visit for counseling), which references the difficult nature of the patient's condition and the time spent with the patient.

Explanatory Code "BH" – Important Reminder

Explanatory Code "BH" explains that your claim is being held for future processing, and will be processed on a future remittance statement.

Please do not rebill any claims that have been assigned explanatory code "BH", as this contributes to MSP's backlog of claims and slows down processing time.

If claims are overage as a result of processing delays and you disagree with MSP's adjudication, submission code "X" may be used (with a note record), as outlined in a broadcast message sent with your May 31, 2002, remittance statement.

Billing Errors Identified by Audit

As a result of MSP audits, there are a number of specific areas where inappropriate billing practices have been identified. The following items do not represent an exhaustive listing of the types of billing "errors" that have arisen from audits, but do represent the most common issues that have been found. Practitioners should ensure that they are aware of the billing requirements related to these issues and that billings are in compliance with the *MSC Payment Schedule* and the *Medical and Health Care Services Regulation*. Practitioners and their office staff may also find our MSP Web site useful:
www.healthservices.gov.bc.ca/msp/index.html

Frequency of Services

The frequency of repeated services, in most cases, is necessary and justified. In some cases, however, the physicians' patient-problem mix does not differ significantly from that of other physicians in the peer group, and reasonable care would not require such a high frequency of services. Maintaining adequate clinical records is very important under these circumstances. Please refer to Preamble B-2.

Medical Records

The *MSC Payment Schedule Preamble section B, paragraph 2* states that a medical record is not considered complete and adequate unless it contains the following:

- date and location of service
- identity of patient and attending physician
- presenting complaint and symptoms
- all previous history including family history
- relevant results of a systemic enquiry
- identifies the extent of examination
- results of any investigations carried out during the examination
- summation of problem and management

Complete Examination 00101

Fee item 00101 is to be billed for a complete examination that includes a history of past and present illness, new complaints, family history, functional enquiry, physical examination, differential and provisional diagnosis. Routine or periodic complete examinations (check ups) are not a benefit under MSP. For a more detailed explanation see Preamble B-4.a.

Counseling Visits 00120

The criteria for billing fee item 00120 is listed in Preamble B section 4-c. In particular, the physician must spend a minimum of 20 minutes discussing with the patient, caregiver or spouse a difficult medical condition or significant emotional distress concerning a condition. Counseling should not be claimed for advice that is a normal component of any visit.

Emergency Call-Out

Fee item 00112 is to be charged only when one must immediately leave home, office or hospital to render immediate care, and only when the call is placed between 0800 hrs. and 1800 hrs. as outlined in the *Payment Schedule*, page 2-1.

A call to hospital emergency department while at the hospital should be billed under the appropriate on-call, on-site hospital visit listings or the procedure.

Multiple Surgeries

When two or more similar procedures are performed under the same anesthetic, or when two or more procedures are performed in the same general area, whether through the same incision, an extension of that incision or through separate incisions, the procedure with the greater listed fee amount may be claimed in full and the fee for additional procedures are reduced to 50 per cent unless otherwise stated in the fee schedule. More information regarding billing multiple surgeries can be found in Preamble B 9-e.

MSP CareCard Replacement Fee

A fee is normally charged to replace lost, stolen or damaged CareCards. Effective October 1, 2002, the fee increased to:

$20 for one card,
$34 for two cards and
$50 for three or more cards.

The last two amounts ($34 and $50) apply only if cards are being requested for family members covered under the same account.

MSP Premium Billing

The Ministry of Provincial Revenue is now the central point for administration and collection of revenue on behalf of the province.

Effective September 2002, the Ministry of Provincial Revenue began issuing MSP premium invoices, processing MSP premium payments, and collecting overdue accounts. MSP continues to determine eligibility, handle enrollment, administer medical coverage and issue CareCards for B.C. residents.

New Legislation

On July 5, 2002 Bill 18 – the *Health Statutes Amendment Act 2002* became law. Under this new legislation, when the Medical Services Commission orders a practitioner to repay an amount under s 37 of the *Medicare Protection Act*, it must now add a surcharge and interest to that amount.

The surcharge is calculated from the period in which the audit takes place and reflects 5 per cent of the quantification amount. Interest is payable at a rate equal to that of the banker to the government and begins accruing following the last day of the audit period. These provisions also apply to consent orders under a negotiated settlement.

Coming Soon – Rural Retention Premium

Effective January 1, 2003, all physicians (except Psychiatrists currently receiving GDPR) including resident physicians, itinerant physicians and locum tenens that provide services in eligible rural communities will receive a Rural Retention Fee Premium on fee for service claims. The Rural Retention Program will replace existing retention payment incentives, including the Northern and Isolation Allowance (NIA).

The level of payment for the fee premium will be based upon the location of service in an eligible rural retention community rather than the community where the physician resides. Physicians will need to have the capability to specify the location of service on each fee for service claim. The exact method of implementing this is yet to be determined. A listing of eligible Rural Retention Program communities and instructions on applying the correct codes to the fee for service claims will be mailed out to all physicians in the near future.

Resident physicians in eligible Rural Retention communities may also be entitled to an annual flat fee sum. More information on the flat fee sum will also be forthcoming in the near future.

If you have any questions or concerns please contact Sharron Wickens at (250) 952-3042.

Pharmacare Special Authority Process

Changes effective for prescriptions filled October 1, 2002, or later

Introduction of Assumed Special Authorities

Many medications prescribed by specialists under prescriber or specialty exemptions are routinely granted approval when another prescriber submits a subsequent Special Authority (SA) request.

To further simplify ongoing approval, Pharmacare is introducing Assumed Special Authorities.

For prescriptions filled on or after October 1, 2002, in most cases, if a medication has been prescribed by an exempted specialist, enhanced PharmaNet system functionality will automatically create indefinite SA approval for the patient. An SA request from the general practitioner, or other prescriber, will no longer be required to maintain coverage of the drug for the patient.

Before issuing a prescription for such a medication, your office may do one of the following:

- Check the patient's chart to verify that the medication was initially prescribed by a specialist. If the medication was initially prescribed by a specialist and is not on the list of exclusions (see reverse of this form), you may elect not to submit an SA request.*
- Submit an SA request. As all incoming requests will first be screened for existing approval, if an Assumed SA is in place, indefinite approval can be confirmed more quickly.

  Please also note that the Pharmacare Web site (www.healthservices.gov.bc.ca/pharme) indicates whether or not a practitioner or prescriber SA exemption exists for a particular SA medication.

Over time, assumed SAs will reduce the number of SA requests physicians are required to submit and the corresponding decrease in workload for Pharmacare SA staff will promote improved turnaround times for other SA requests.

For your convenience, the following page provides a list of:

- medications not included in the assumed SA process, and
- medications currently eligible under specialty SA exemptions.

Prescriber SA Exemption
A prescriber SA exemption confers coverage of a specific medication to all eligible patients of a specific presriber.

Specialty SA Exemption
A specialty SA exemption confers coverage of a specific medication to all eligible patients of a specific specialty group (for example, rheumatologits or oncologists).

Drugs not included in the assumed SA process

The following medications, although they continue to qualify for practitioner and specialty exemptions, are not eligible for assumed SAs:

- antibiotics
- botulinum toxin
- infliximab and etanercept
- ondansetron
- ophthalmic quinolones
- proton pump inhibitors
- investigational drugs
- leuprolide

Drugs currently eligible under specialty exemptions

The list of included medications on page 11 is current as of the publication date. For more current information on specific drugs eligible under specialty exemptions, visit the Pharmacare Web site or call Pharmacare. Note: In addition to these specialty exemptions, medications eligible under practitioner SA exemptions (with the exception of those noted above) also qualify for assumed SAs.

Specialty	Medications
Cardiology	amlodipine, nicardipine, nifedipine
Clinical immunology & allergy	budesonide/formeterol, formoterol, fluticasone/salmeterol, salmeterol
Haematology	benzydamine, fentanyl, granisetron, hydromorphone, dronabinol, morphine suppositories
Medical oncology	benzydamine, fentanyl, granisetron, hydromorphone, dronabinol, morphine suppositories
Nephrologists	amlodipine, nicardipine, nifedipine
Neurology	sumatriptan injection
Pediatric cardiology (RDP Policy Pediatric Exemption)	amlodipine, benazepril, diclofenac sodium, diflunisal, enalapril, famotidine, fenoprofen, flurbiprofen, fosinopril, indomethacin, isosorbide, ketoprofen, lisinopril, misprostol/ diclofenac, nabumetone, naproxen potassium, nicardipine, nifedipine, nitroglycerin, nizatidine, pentaerythritol, piroxicam, ranitidine, salsalate, sulindac, tenoxicam, tiaprofenic, tolmetin
Pediatrics (RDP Policy Pediatric Exemption)	amlodipine, benazepril, diclofenac sodium, diflunisal, enalapril, famotidine, fenoprofen, flurbiprofen, fosinopril, indomethacin, isosorbide, ketoprofen, lisinopril, meloxicam, misoprostol/diclofenac, nabumetone, naproxen potassium, nicardipine, nifedipine, nitroglycerin sustained release, nizatidine, pentaerythritol, piroxicam, ranitidine, salsalate, sulindac, tenoxicam, tiaprofenic, tolmetin
Pediatric general surgery (RDP Policy Pediatric Exemption)	diclofenac sodium, diflunisal, famotidine, fenoprofen, flurbiprofen, indomethacin, isosorbide, ketoprofen, misoprostol/ diclofenac, nabumetone, naproxen potassium, nitroglycerin, nizatidine, pentaerythritol, piroxicam, ranitidine, salsalate, sulindac, tenoxicam, tiaprofenic, tolmetin
Physical medicine & rehabilitation	diclofenac sodium, diflunisal, fenoprofen, flurbiprofen, indomethacin, ketoprofen, meloxicam, misprostol/diclofenac, nabumetone, naproxen potassium, piroxicam, salsalate, sulindac, tenoxicam, tiaprofenic, tolmetin
Radiation oncology	benzydamine, fentanyl, granisetron, hydromorphone, dronabinol, morphine suppositories
Radiation (therapeutic) and radiation oncology	benzydamine, fentanyl, granisetron, hydromorphone, dronabinol, morphine suppositories
Respiratory medicine	budesonide/formoterol, fluticasone/salmeterol, formoterol fumarate, salmeterol, salmeterol/fluticasone
Rheumatologists	chlorambucil, chloroquine phosphate, diclofenac sodium, diflunisal, fenoprofen, flurbiprofen, indomethacin, ketoprofen, meloxicam, methotrexate, misprostol/diclofenac, nabumetone, naproxen potassium, piroxicam, salsalate, sulindac, tenoxicam, tiaprofenic, tolmetin

Changes in Pharmacare Contact Information

On August 19, 2002, Pharmacare Operations moved to the main Ministry of Health Planning/ Health Services location in Victoria, the Richard Blanshard Building. On August 30, 2002, the Pharmacare Burnaby office closed. The move has not affected:

- Contact numbers used by the public and pharmacists
- Pharmacare mailing address (PO Box 9655 Stn Prov Govt, Victoria BC V8W 9P2)

The move has affected telephone and fax numbers for physicians. Please use the numbers given below and re-enter any speed dial numbers as appropriate:

Physician Hotline
Pharmacare is requesting that physicians not provide the Physician Hotline Telephone Numbers to patients as this practice prevents a timely response for urgent incoming requests. The Hotline telephone numbers strictly for physician use are:

(Victoria)	250-952-2581 or
(rest of B.C. toll-free)	1-877-657-1188.

The public may contact the **PharmaNet Help Desk** at:

Vancouver/Lower Mainland	604 682-6849;
Greater Victoria	250 952-2866;
Rest of B.C. toll-free	1-800-554-0250

Enclosed with this newsletter is the patient handout: Pharmacare Coverage of Early Fills of Medications

Special Authority Request Fax Lines

Victoria	250-952-1065
Other areas within B.C.	1-800-609-4884 (toll-free)

New Low Cost Alternative/Reference Drug Program booklet
The new booklet, effective October 15, 2002, is available on the Pharmacare Web site (www.healthservices.gov.bc.ca/pharme) in Adobe Acrobat (printable) format. Most Internet users will already have Adobe Acrobat software installed but, if necessary, it is available (free of charge) via links provided on the Pharmacare Web site.

Drugs under review

The following drug submissions are currently under review by the Drug Benefit Committee of Pharmacare:

anakinra (KINERET®)
ancestim (STEMGEN®)
alfuzosin (XATRAL®)
bimatoprost 0.03% ophth soln (LUMIGAN®)
bisoprolol (MONOCOR®), resubmission
botulinium toxin (BOTOX®), new indication
clopidogrel (PLAVIX®) new indication
donepezil (ARICEPT®), resubmission
eprosartan (TEVETEN®), resubmission
filgrastim (NEUPOGEN®), new indication
glimepiride (AMARYL®)
mometasone furoate (AZMAX Twisthaler®)
rabeprazole (PARIET®)
repaglinide (GLUCONORM®), resubmission
rivastigmine (EXELON®), resubmission
tacrolimus ointment (PROTOPIC®)
17-b-estradiol (VAGIFEM®)
unoprostone 0.15% (RESCULA®)

New Explanatory Codes

JR Critical Care (01411 - 01441) has been paid to another physician. Therefore, your claim has been paid under the appropriate fee item.

JS Day 2 rates for Critical Care apply when the service is preceded by a consultation (after 2200 hours) by a team member.

JT Claims for percutaneous transluminal coronary angioplasty/additional vessel (00840 - 00842) are payable at 75 per cent when billed by a team member.

JU Comprehensive Care (01413 - 01443) has been paid to another physician. Therefore, we are unable to process your claim for payment.

JW 01200 - 01202 and 01205 - 01207 are not payable in addition to Adult and Paediatric Critical Care Fees (01411 - 01441, 01412 - 01442 and 01413 - 01443).

QX A new authorization is required per Preamble B.16.1(9). Please rebill after a new authorization is received, if applicable.

The following explanatory code has been reworded:

JP Ventilatory Support (01412 - 01442) has been paid to another physician. Therefore, your claim has been paid under the appropriate fee item.

Standard Out-patient Prenatal Cytogenetic Testing Requisition Form

Enclosed with this newsletter is a copy of the revised *Standard Out-patient Prenatal Cytogenetic Requisition* Form. The patient demographic portion has been amended to resemble the format used on other Standard Requisition Forms.

The Advanced Maternal Age portion (#1) of the form has also been amended to conform to the age parameters of the Prenatal Cytogenetic Testing Protocol.

All laboratories are encouraged to introduce the revised requisition form as soon as possible.

Changes to MSC Payment Schedule

The Medical Services Commission has approved changes to the MSC Payment Schedule as recommended by the British Columbia Medical Association. An information package with details and effective dates for new fee items, amendments, and increases to existing fees are included with this newsletter. Watch for a broadcast message announcing that the Teleplan electronic fee schedule has been updated to reflect these changes.

Laboratory Requisition

All laboratories are encouraged to introduce the Revised *Standard Out-Patient Laboratory Requisition* form as soon as possible. This requisition replaces the previous requisition irrespective of Category approval. However, MSC Audit Recovery Policy regarding non-compliance with the *Standard Out-Patient Laboratory Requisition* form will apply after January 1, 2003. All laboratories must be using the new requisition by January 1, 2003.

Although most of the material on the enclosed form is considered mandatory, some details may be omitted at the laboratory's discretion. The name and the address of the laboratory may be added, but the content may not be altered and tests may not be added. There is no restriction on the size of the form, colour of ink, or type of paper.

Using your Note Records

MSP receives a large volume of correspondence that is not required, which leads to processing delays. To help MSP process your claims more quickly, please use your note record whenever possible instead of sending paper correspondence.

For example, when billing a laparoscopy with an abdominal surgery where a laparascopic procedure was attempted and subsequently converted to an open procedure, a note record stating "laparoscopic procedure failed, converted to open" is sufficient. You do not need to send the operative report.

A note record is often sufficient to support claims for fee items such as 00081, 00082, and 00083 as well as repeat stress tests (fee items 00334 – 00336). For example. Correspondence should only be submitted in the following circumstances:

- A request for information has been made directly by MSP.
- Your account has been refused "F9" and you are providing additional information that cannot be sent in a note record (such as an operative report) to support a rebilling.
- There is a requirement in the *Payment Schedule* to provide an operative report.
- You are billing a service not listed in the *Payment Schedule* under a miscellaneous item, and that service cannot be described in a note record.

Your cooperation is greatly appreciated.

Surgical Assists for Concurrent Surgery to Different Patients

When billing both time-based surgical assist fees (e.g. fee items 00193, 70019, 70020) and non-time based surgical assist fees (e.g. fee items 00194 – 00197) for concurrent surgery to different patients, the time spent providing surgical assistance on the concurrent surgery must be deducted from the time-based fees.

Examples:

1. If assisting at open-heart surgery (e.g. fee items 07908 and 07909) from 09:00 to 13:00, and in addition asked to assist at coarctation of the aorta (fee item 07820) from 10:15 to 11:45, the billing should be as follows:

Patient A: 00193 X 10 - Indicate in note record: surgery from 09:00 – 10:15 and recommenced at 11:45 – 13:00 (concurrent surgery 10:15 to 11:45)

Patient B: 00197 X 1

2. Specialist assisting at a "C" designated surgery (i.e. fee item C77185 – ruptured aneurysm, with grafting) from 09:00 to 12:30 is requested to assist at an appendectomy (10:00 – 10:30). Billing should be:

Patient A: 70019 x 1
70020 x 4 (indicate in Note Record – surgery from 09:00 to 10:00 and 10:30 to 12:30 – with concurrent surgery from 10:00 to 10:30)

Patient B: 00195 x 1

MSP BULLETIN FALL/WINTER 2002

The Medical Services Plan's Bulletin is provided to help physicians identify patients whose MSP benefits have payment restrictions. This Bulletin provides important billing information for physicians only. Thank you for respecting the confidential nature of this information.

The Bulletin is an updated listing of restricted MSP enrollment numbers for clients who have signed a legal *Agreement of Limitation* form which limits MSP payment responsibilities to one primary care physician. If care is provided by other physicians, the charges must be made directly to the clients. MSP will not accept payment responsibility unless special circumstances are clearly stated. An example of this would be medical care that has been provided by an emergency physician in the hospital emergency room.

MSP is concerned about the potential misuse of CareCards and strongly recommends a complete check of CareCard information at all first appointments. If you suspect any unusual use of a CareCard, please request a second piece of picture identification in order to verify that the CareCard is being presented by the person named on the card.

PHN	Birthdate (MM/YY)	Sex M/F	Physician Number
9013676868	12/54	M	06541
9023967395	02/54	F	03023
9025293026	12/58	M	24287
9029287062	06/52	F	06061
9029345046	05/43	F	06541
9029596344	09/55	M	00792
9030165823	12/54	F	05334
9030205973	05/54	M	26411
9030780581	05/29	F	08241
9030861738	10/45	M	01604
9032398914	08/56	M	09760
9032842679	05/59	F	01229
9034248181	10/59	F	07384
9034793801	06/59	F	06468
9035162781	06/34	F	01454
9035294522	07/58	M	23759
9041726364	07/56	F	03733
9052634089	06/39	M	00441
9071584167	06/48	M	09604
9089058947	11/61	F	03462
9104870848	04/67	F	09443
9107346403	08/54	M	08365

Audiograms

Audiograms must be medically necessary and not used for screening or baseline assessment. They may be considered medically necessary only when the presenting complaint, history or a detection manoeuvre done in the course of the physical examination (e.g. the whispered voice test, tuning fork test or finger rub test) provides evidence of a hearing loss, or when the patient is specifically referred for hearing assessment by the attending physician.

The medical record must document the above indications.

List of Inserts

1) *Standard Out-Patient Prenatal Cytogenetics Requisition* form
2) *Standard Laboratory Requisition* form
3) Update BC Palliative Care Benefits Program, September 2002
4) Chronic Disease Management: A Snapshot of Diabetes Care in British Columbia 2000/2001
5) Update to the *Payment Schedule*
6) Full Service Family Practice Questionnaire
7) Fee Schedule Changes
8) Correcting Misinformation on MSP Billing Rules
9) Chronic Disease Management: The Failing Heart
10) Pharmacare Coverage of Early Fills of Medications

Northern and Isolation Travel Assistance Outreach Program (NITAOP)

The Northern and Isolation Travel Assistance Outreach Program (NITAOP) provides travel assistance and a travel time honorarium for approved visiting specialists and family medicine physicians to deliver outreach services to approved rural communities. Communities covered under the 2002 Subsidiary Agreement for Physicians in Rural Practice (RSA) may be eligible for funding, depending on availability of local services, and the specialty.

Health authorities/Agencies are responsible for recruiting the physicians, scheduling the visits, and submitting the annual funding requests. Following approval, visiting physicians are paid directly by the Medical Services Plan (MSP) upon receipt of the travel expense form and applicable receipts.

For further information on this Program, including eligibility, please contact Sharron Wickens at (250) 952-3042.

Update to Teleplan's Internet Option

Teleplan's Internet option has been available in production since January 2002 for all Teleplan users and has been very successful.

The Teleplan Internet option is available for general use by all Teleplan Simpc users who have internet capable computers. If you have ADSL or Cable or a private ISP Dialup modem then all you need to do is call your vendor and ask about their migration progress.

We encourage you to migrate as soon as your vendor has shipped you their modified software or have provided you with the necessary information to use the standard Internet Explorer/Netscape Browser to access our site and transmit your data to MSP.

If you do not have ISP access, contact MSP's Teleplan Support at: 1 800 663-7206 for access instructions to our SpanDial Teleplan Web dialup lines.

We currently have approximately 500 sites sending and receiving claims over the Internet.